STATE OF IOWA

CHESTER J. CULVER, GOVERNOR
PATTY JUDGE, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
EUGENE I. GESSOW, DIRECTOR

October 31, 2008

GENERAL LETTER NO. 3-B-5

ISSUED BY: Office of the Deputy Director for Field Operations

SUBJECT: Employees' Manual, Title 3, Chapter B, ***STATE RESOURCE CENTERS***, Contents (page 4), revised, Contents (page 5), new; pages 2, 3, 5 through 15, 17, and 88 through 96, revised; and pages 97 through 115, new.

Summary

The chapter is revised to include new end of life policies. Included are policies covering:

- Hospice care,
- Confidentiality,
- Internal reporting,
- External reporting,
- Autopsies,
- Handling the decedent's property, and
- The mortality review process.

New legal basis for policy is added.

The term "family" is redefined as "family contact" in the whole chapter. New definitions are added including:

- Expected death,
- Family contact,
- Health care professional,
- Independent physician,
- Leave,
- Next of kin,
- Profession, and
- Unexpected death.

Effective Date

Upon receipt.

Material Superseded

Remove the following pages from Employees' Manual, Title 3, Chapter B, and destroy them:

Page	Date
Contents (page 4)	September 22, 2006
2, 3, 5-8	September 22, 2006
9, 10	October 20, 2006
11-15, 17, 88-96	September 22, 2006

Additional Information

Refer questions about this general letter to the Deputy Director, Division of Field Operations.

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Legal Basis

Iowa Code section 218.1 provides that the director of the Department of Human Services has full authority to control, manage, direct and operate the Department's institutions and may assign this authority to the superintendents at the resource centers.

Iowa Code section 218.13 requires the Department to conduct background checks of any person who is:

- Being considered for employment involving direct responsibility for an individual or with access to an individual when the individual is alone; or
- Requesting permission to reside on the grounds of the resource center.

The purpose of the background check is to determine whether the person has been convicted of a crime or has a founded child abuse or dependent adult abuse record. If so, the Department is required to determine if the conviction or founded abuse warrants prohibition of the person from employment or residing on grounds.

Iowa Code section 218.64(2) requires the county medical examiner to conduct a preliminary investigation of all deaths at institutions covered by Iowa Code Chapter 218. Iowa Code section 218.65 governs the handling of the property of an individual who dies at a state institution.

Iowa Code Chapter 222 outlines the authority and responsibilities of the state resource centers. Iowa Code section 222.12 requires the county medical examiner to conduct a preliminary investigation of all deaths at the state resource centers.

Iowa Code sections 232.67 through 232.77, Iowa Code Chapter 235A, and 441 Iowa Administrative Code Chapter 175 define child abuse and require reporting, investigation, and actions to be taken to protect children a from abuse.

Iowa Code Chapter 235B and 441 Iowa Administrative Code Chapter 176 define dependent adult abuse and require reporting, investigation, and actions to be taken to protect dependent adults from abuse.

Iowa Code sections 225C.25 through 225C.32 provide that persons with mental retardation, developmental disabilities, brain injury, or chronic mental illness retain the same rights granted to all other persons and cannot be denied these rights without due process.

Iowa Code sections 331.802 and 331.805 detail the responsibilities of the county medical examiner in deaths of public interest and define all deaths at an institution governed by Iowa Code Chapter 218 as deaths of public interest.

Iowa Code section 709.1 defines sexual abuse.

Title XIX of the Social Security Act and 42 CFR §483.420(a) require facilities to ensure the rights of clients as a condition of participation in the Medicaid ICF/MR program.

Civil Rights of Institutionalized Person Act (CRIPA) at 42 USC §§1997j requires the United States Attorney General to investigate conditions of egregious or flagrant deprivation of rights of persons residing in public institutions.

Public Law 106-402, the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (DD Act), codified at 42 USC 15001, provides that programs, projects, and activities for persons with developmental disabilities shall be carried out in a manner consistent with supporting the rights of the persons served.

Definitions

"Abuse" occurs when a caretaker intends to inflict harm on an individual or, where the caretaker fails to act or acts in a reckless manner, which has the consequence of causing that individual harm, or has the potential to cause such harm. Abuse may also occur when a caretaker threatens harm in a manner that a reasonable person believes that the harm might occur. Types of abuse include:

- **Physical abuse:** An act that causes, or may have caused an injury to an individual. Physical abuse includes but is not limited to:
  - Hitting, slapping, pushing, pinching, throwing objects directed at the individual or otherwise striking an individual,
  - Physical assault,
  - Corporal punishment (physical punishment for an individual's actions),
  - Use of excessive force (failure to use least restrictive interventions),
  - Unauthorized use of restrictive interventions including restraint, seclusion, aversive conditioning, time out or punishment, and
  - Incitement to act, which includes circumstances where caretakers instigate individuals to inflict harm on another individual.

- **Neglect or denial of critical care:** Actions or inactions that result in the failure to provide food, shelter, clothing, physical or mental health, supervision, or any other care necessary to prevent imminent risk of or potential risk for harm or death. Neglect or denial of critical care includes but is not limited to:
  - Lack of appropriate supervision of individuals which result in an elopement,
  - Withholding of food or clothing or other activities to punish an individual or any other such action which is not included in the individual's Individual Support Plan,
  - A medication error when it results in an immediate or imminent health risk,
  - Lack of appropriate supervision of individuals which results in sexual contact between minors,
  - Lack of appropriate supervision of individuals which results in non-consensual sexual contact between adult individuals or when one of the adults is incapable of giving consent, or
  - Lack of appropriate supervision which results in assault.
- **Exploitation:** An act or process of taking advantage of an individual or an individual's physical or financial resources for personal gain. Exploitation includes but is not limited to:
  - Misleading or deceiving an individual to gain access to personal resources,
  - Stealing an individual's personal property, or
  - Requests for or using individuals to perform work duties for the caretaker or to perform services for the state resource center that are not in accordance with the individual's support plan.

"Active treatment" means continuous training to assist individuals acquire their maximal independence through formal and informal activities enhancing their optimal physical, emotional, social, intellectual, and vocational levels of development and functioning.

"Admission" means the acceptance of an individual for full residence at a resource center on either a voluntary or involuntary basis.

"Adult" means an individual 18 years of age or older.

"Adverse drug reaction" means an unexpected and untoward reaction to medication.

"Allegation" means an assertion of misconduct or wrongdoing that has yet to be proven or confirmed by supporting evidence.

"Allied health services" means a group of diverse providers responsible for a portion of integrated healthcare that directly or indirectly impact services to individuals or facilities along the chain of service delivery.

"Aspiration pneumonia" means an inflammation of the lungs and bronchial tubes caused by inhaling foreign material, usually food, drink, vomit, or secretions from the mouth into the lungs.

"Assault" means the actual physical or sexual attack of an individual or threat of a physical or sexual attack. Sexual assault occurs between individuals when one of the individuals has not given consent or when one of the individuals is incapable of giving consent. See Iowa Code section 708.1.

"Behavior support plan" or **"BSP"** means a component of the individual support plan that is a comprehensive, individualized plan outlining behavioral issues impacting a person's life and interventions for addressing those behaviors.

"Bio-psycho-social" means a philosophy identifying the inter-relatedness and interdependence of the biological, psychological, and social components of a human being.

"Board of supervisors" means the elected governing body of a county as defined in Iowa Code Chapter 331.

"Bowel obstruction" means an intestinal obstruction involving a partial or complete blockage of the bowel that results in the failure of the intestinal contents to pass through.

"Business day" means a working day in the usual Monday-through-Friday workweek. A holiday falling within this workweek shall not be counted as a business day.

"Caretaker" means an employee, contractor, or volunteer of a resource center.

"Catchment area" means the group of counties, designated by the deputy director, that each resource center is assigned to serve.

"Central point of coordination process" means the process defined in Iowa Code section 331.440(1)(a).

"Child" means an individual under the age of 18.

"Choking" means a blockage of the upper airway by food or other objects, preventing an individual from breathing effectively. Choking can cause a simple coughing episode or complete blockage of the airway and lead to death.

"Clinical indicator" means a measure assessing a particular health care outcome determined to have a clinical significance or correlation to the quality of care.

"Clinical services" means a group of specialized practices addressing the bio-psycho-social needs of an individual. For the purposes of this policy, these practices include the specialized care provided by licensed practitioners in the fields of dentistry, medicine, neurology, neuropsychiatry, nursing, nutrition, occupational therapy, pharmacology, physical therapy, psychiatry, psychology, and speech and language pathology.

"Community integration" means the process of including persons with disabilities in the environments, activities, and social networks of typical persons. This term is also used interchangeably with "inclusion."

"Competency-based training" means a type of training in which the student must demonstrate, through testing or observed practicum, a clear understanding of the learning material presented.

"Comprehensive functional assessment" or **"CFA"** means a set of evaluations identifying an individual's strengths and preferences; functional and adaptive skill levels; disabilities and possible causes; and needs.

"Contractor" means a person employed under a personal services contract by the facility that has direct personal contact with an individual.

"Corporal punishment" means the use of any physical force to inflict punishment for an individual's actions.

"Corrective action" means action to correct a situation and prevent reoccurrence of the situation. Corrective action may include but is not limited to, program change, system change such as an environmental improvement, or disciplinary action.

"County board of supervisors" means the elected board of supervisors of an Iowa county.

"Date of application" means the date that the Department's Field Operations Support Unit receives the application by the county board of supervisors or the court's request for a diagnostic evaluation.

"Department" means the Iowa Department of Human Services.

"Deputy director" means the Department's deputy director for field operations.

"Dignity of risk" means the concept that individuals, having the right to self-determination, also have the right to expose themselves to experiences which, while posing some risk, open doors to learning and growth that would have remained closed had the risk not been taken.

"Discharge" means another provider has accepted responsibility for providing services and supports to an individual and the resource center no longer has legal responsibility for proving direct services to the individual.

"Discharge plan" means the plan developed for an individual that identifies the major barriers to discharge and the strategies that will be developed and implemented to overcome the barriers to enable the individual to move to the most integrated setting appropriate to the individual's needs.

"Due process" means assuring that an individual's rights are not limited unless done so by court order through a process defined by law or through an individual's approved program plan process that includes informed consent.

"Elopement" occurs when:

- An individual's location is unknown by staff who are assigned responsibility for oversight; or
- An individual who is allowed to travel independently on campus does not arrive or return when expected; or
- An individual who is either on or off campus leaves without permission and is no longer in continuous oversight.

"Employee" means a full-time, part-time, or temporary person on the payroll of the facility.

"Entities responsible for funding" means the individual's county of legal settlement or the Iowa Department of Human Services.

"Essential supports" means the medical, mobility, nutritional, and behavioral supports that are essential to an individual's health and safety. Absence of an essential support would immediately negatively compromise the individual's health, safety, or behavior. Essential supports are to be in place before an individual is placed.

"Evidence-based practice" means the integration of best research evidence with clinical expertise and patient values.

"Expected death" means the death of an individual who is diagnosed with a terminal illness or condition and whose health status, based on current medical knowledge, is not expect to improve but likely to deteriorate. The illness or condition is expected to be fatal within a reasonable period, and the determination is supported by the individual's treatment record and course of treatment.

"External review" means a review conducted by persons from outside the resource center who represent the specialties that are required to be reviewed.

"Facility risk data profile" means the aggregate data collected on the type of risks experienced by individuals who reside at a resource center which is used for identifying trends, patterns, quality management and performance improvement.

"Fall" means unintentionally coming to rest on the ground, floor, or other lower level, but not as a result of syncope or overwhelming external force. The following are **not** to be classified as falls:

- An individual being pushed, shoved or aggressed against causing him to go to the ground, floor, etc. This is an incident of **aggression**.
- An individual intentionally sitting on the ground, floor, pavement, etc. This is most likely either the individual choosing to rest or behaviorally communicating that he does not want to participate in what is being asked or suggested of him.

"Family contact" means:

- The parent of a minor individual, or
- The family member an adult individual has designated in writing to receive information concerning the individual's services at the resource center, or
- A person who has been legally authorized to make care decisions for the individual if the individual loses decision-making capacity, often referred to as a surrogate decision-maker.

"Full residence" means the determination that the individual meets all the admission requirements and has been admitted for an ongoing stay to receive support and treatment services.

"Grievance" means a written or oral complaint by an individual involving a rights violation, or unfairness to the individual, or any aspect of the individual's life that the individual does not agree with.

"Guardian" means the person other than a parent of a child who has been appointed by the court to have custody of person of the individual as provided under Iowa Code section 232.2(21) or 633.3(20).

"Health care professional" means a physician, nurse practitioner, physician's assistant, or a registered nurse.

"High risk or dangerous behavior" means a behavior or action on the part of an individual that a reasonable and prudent person would deem as of immediate danger to the individual's health or safety or the health or safety of another person. This includes threatened behavior when the individual has the immediate opportunity and capacity to carry out the behavior.

"Immediate clinical review" means a review initiated by a treatment program manager or QMRP by the end of the next working day from when a problem is identified to address:

- Whether appropriate treatment and supports were in place, and
- What changes are needed to appropriately address the problem.

The clinician or a group of clinicians appropriate to evaluate the cause of the problem shall conduct the review. The treatment program manager or QMRP shall determine the participation of other members of the individual's interdisciplinary team based on the individual and the problem involved.

"Incident" means any action, situation, behavior, or occurrence that is not consistent with the care, treatment, or habilitation plan of an individual or that may affect the health or safety of the individual.

"Incident review committee" means the committee responsible for the overall monitoring, reviewing, and determining the effectiveness of a resource center's implementation of incident management policies and corrective actions. At a minimum, the committee shall include the superintendent, the persons directly responsible for the program and treatment services, representatives from psychology and nursing, and the director of quality management.

"Independent physician" means a licensed physician who is not an employee of the resource center and who has no personal or professional connections to the individual who died.

"Individual" means any child or dependent adult residing at and receiving services from a resource center. For the policies on human rights and abuse, it also includes any child or dependent adult not residing but receiving services from a resource center.

"Individual education plan" or **"IEP"** means the primary document outlining an individual's educational needs and the services and supports required for the individual to receive a free appropriate public education in the least restrictive environment.

"Individual support plan" or **"ISP"** means the plan of treatment, education, and support services developed for each individual to address the individual's identified needs.

"Informed consent" means an agreement to participate in an activity by an individual or the individual's parent, guardian, or legal representative based upon an understanding of:

- A full explanation of the procedures to be followed, including an identification of those that are experimental.
- A description of the attendant discomforts and risks.
- A description of the benefits to be expected.
- A disclosure of appropriate alternative procedures that would be advantageous for the individual.
- Assurance that the consent is given freely and voluntarily without fear of retribution or withdrawal of services.

"Injury of unknown origin" means an injury whose origin or etiology cannot be conclusively determined, despite preliminary or formal investigative efforts.

"Interdisciplinary team" or **"IDT"** means a collection of people with varied professional backgrounds who develop one plan of care to meet an individual's need for services.

"Leave" means any status where the individual is not physically present in the resource center but has not been discharged and the resource center retains some responsibility for the care, oversight or treatment of the individual.

"Legal representative" means a person, including an attorney, who is authorized by law to act on behalf of an individual.

"Legal settlement" means the determination made under Iowa Code sections 252.16 and 252.17 to identify whether one of the 99 Iowa counties has a legal obligation to provide financial support for an individual.

"Mandatory reporter" means:

- For adult abuse, a person as defined in the Iowa Code section 235B.3(2).
- For child abuse, a person as defined in the Iowa Code section 232.69(1).

"Medical emergency" means a change in an individual's health status that requires emergency medical intervention, including but not limited to use of the Heimlich maneuver, use of CPR, defibrillation, calling 911 for emergency medical services, or hospitalization.

"Medication error" means not administering a medication as ordered or administering a medication without authorization.

"Mental retardation" means a condition where all of these factors are present:

- Significantly subaverage intellectual functioning: an intelligence quotient (IQ) of approximately 70 or below on an individually administered IQ test (for infants, a clinical judgment of significantly subaverage intellectual functioning) as defined by the ***Diagnostic and Statistical Manual of Mental Disorders***, Fourth Edition, American Psychiatric Association.
- Concurrent deficits or impairments in present adaptive functioning (i.e., the person's effectiveness in meeting the standards expected for the person's age by the person's cultural group) in at least two of the following areas: communication, self-care, home living, social and interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety.
- Onset before the age of 18. (Criteria from ***Diagnostic and Statistical Manual of Mental Disorders***, Fourth Edition (DSM IV-TR), 2000 revision, American Psychiatric Association)

"Next of kin" means, as defined in Iowa Code section 144.56, the following persons in descending order:

- The individual's spouse.
- The individual's adult son or daughter.
- Either parent of the individual.
- The individual's adult brother or sister
- The individual's guardian at the time of death if the guardian claims the body.
- Any other person authorized or obligated to dispose of the individual's body.

"Nonessential supports" means those supports that are a necessary part of a complete individual support plan for an individual but their short-term absence is not an immediate threat to the individual's health or safety. Nonessential supports are to be in place no later than 60 days after the individual is placed.

"Official designated agent" means a person designated to act on behalf of a board of supervisors by a recorded vote of the board of supervisors.

"Outpatient admission" means a person is provided a service but is not admitted to residence, except the term includes individuals admitted to residence for a diagnostic evaluation for determining the appropriateness of a court ordered admission.

"Parent" means a natural or adoptive mother or father of a child but does not include a mother or father whose parental rights have been terminated.

"Performance measure" means a type of indicator assessing a particular process determined to affect quality of care or compliance.

"Perpetrator" means a person who has been found, under the law, to be responsible for the abuse of a child or a dependent adult.

"Physical injury" means:

- Damage to any bodily tissue to the extent that the tissue must undergo a healing process in order to be restored to a sound and healthy condition, or
- Damage to any bodily tissue that results in the death of the person who has sustained the damage.

"Pica" means the intentional swallowing of all or part of an inedible substance or foreign body.

"Profession" for a professional peer review means medicine and surgery, podiatry, osteopathy, osteopathic medicine and surgery, practice as a physician assistant, psychology, chiropractic, nursing, dentistry, dental hygiene, speech pathology, audiology, pharmacy, physical therapy, occupational therapy, respiratory care, mental health counseling, social work, and dietetics.

"Professional standards" means those as contemporary, accepted professional judgment, and practice standards that are recognized by a profession.

"Programmatic restrictive intervention" means a planned act, program, process, method, or response infringing upon an individual's rights that has been approved by the human rights committee and for which informed consent has been obtained.

"Qualified mental retardation professional" or **"QMRP"** means the leader of the interdisciplinary team (IDT), also referred to as the treatment program manager (TPM). The qualified mental retardation professional is ultimately responsible for ensuring individuals receive all needed bio-psycho-social services and supports in an integrated and coordinated fashion.

"Quality assurance" means all activities that contribute to defining, designing, assessing, monitoring, and improving the quality of healthcare. (Source: The Quality Assurance Project funded through USAID)

"Quality council" means the group of key employee leaders in administration, clinical services, and direct service management that is responsible for oversight of the quality management and performance improvement practices facility-wide.

"Quality improvement" means using collaborative efforts and teams to study and improve specific existing processes at all levels in an organization. (Source: JB Quality Solutions, Inc., ***The Healthcare Quality Handbook*** 2005)

"Quality management" means a planned, systematic, organization-wide approach to the monitoring, analysis, and improvement of organization performance, thereby continuously improving the quality of patient care and services provided and the likelihood of desired patient outcomes. (Source: JB Quality Solutions, Inc., ***The Healthcare Quality Handbook*** 2005)

"Quality of care" means the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

"Residence" means an over night stay at a resource center.

"Residential technical assistance team" or **"RTAT"** means the identified field and central office employees designated to review all voluntary applications or court orders for admission to a state resource center to assure that all reasonable community based options have been considered before an application for admission to a resource center is approved.

"Restrictive intervention" means an act, program, process, method, or response limiting or infringing upon an individual's rights.

"Rights" means the human, civil, and constitutional liberties an individual possesses through federal and state constitutions and laws.

"Rights violation" means any act, program, process, method or response, either through commission or omission, infringing upon or limiting an individual's rights, as defined in this chapter, without due process or without adherence to the emergency restriction policy in this chapter.

"Risk" means an actual or likely condition, injury, or predisposition posing the possibility of danger or loss to an individual.

"Risk/benefit analysis" means weighing the negative impact on the individual's rights against the expected benefit of a rights limitation to determine if the individual's expected outcome, with the rights limitation, is of more value to the individual than the outcome of not limiting the individual's rights.

"Risk management plan" means an individualized interdisciplinary plan that addresses an individual's identified risks and is incorporated into the individual support plan.

"Risk status" means the level of risk severity to the individual.

"Serious injury" means injury, self-inflicted or inflicted by another, resulting in significant impairment of a person's physical condition, as determined by qualified medical personnel. Serious injuries include but are not limited to, injuries that:

- Are to the genitals, perineum, or anus,
- Result in bone fractures,
- Result in an altered state of consciousness,
- Require a resuscitation procedure including CPR and Heimlich maneuver,
- Result in full thickness lacerations with damage to deep structures,
- Result in injuries to internal organs,
- Result in a substantial hematoma that causes functional impairment,
- Result in a second degree burn involving more than 20% total body surface area,
- Result in a second degree burn with secondary cellulitis,
- Result in a third degree burn involving more than 10% total body surface area,
- Require emergency hospitalization, or
- Result in death.

"Transition plan" means the plan developed when an appropriate discharge setting has been identified for an individual that specifies the actions needed to be taken by the resource center to accomplish the discharge and assure success. The plan:

- Identifies the appropriate local county, Department, and provider staff who will be involved in implementation of the plan; and
- Specifies the required resource center actions and the staff and timelines for completion of the required actions.

"Unexpected death" a death that was not the result of a known and documented terminal illness or condition and was not anticipated until the onset of the acute terminal episode.

"Volunteer" means an unpaid person registered with the resource center who has direct contact with an individual.

POLICY ON ADMISSIONS

It is the policy of the Department that admission to a resource center shall be made only for individuals for whom community-based resources are not adequate to meet the individual's current needs. Admission is available only to persons with mental retardation.

All applications for voluntary admissions are screened to assure that community resources have been considered and it has been determined that, based on generally accepted professional standards of care, the resource center is determined to be the most integrated setting based on the individual's current needs.

Applications for voluntary admission of adults shall be made through the central point of coordination process. Applications for minors shall be made through the county board of supervisors.

Involuntary commitments are evaluated before a commitment order is issued to determine if the commitment would be appropriate and if the resource center has adequate facilities to care for the individual.

POLICY ON END OF LIFE

It is the policy of the Department of Human Services that the death of any individual in our care is considered a significant event. Individuals who are at the end of life are provided care and supports in a dignified manner and in compliance with the individual's stated desires. Families play an important role and in accordance with state and federal laws are included in the end-of-life decisions and necessary decisions subsequent to the individual's death.

All deaths are reviewed internally and externally to try to understand of the cause of death. This includes a review of the services provided preceding the death. Unexpected deaths receive additional review including review by an independent physician. The recommendations from reviews are used in the resource center's quality performance improvement process to continuously improve the services provided.

End of Life Policy Principles

Resource center written policies and procedures shall assure that:

- The safety of each individual served shall be basic to the mission of each facility.
- Individuals being served who are at an end-of-life stage shall be provided appropriate medical services and comfort in an atmosphere of dignity and respect.
- Any advance directives in effect shall be complied with.
- All deaths shall be seen as a serious event to be responded to promptly with respect for the deceased individual and the individual's next of kin.
- Every death shall receive a comprehensive review as part of a continuous quality improvement process to:
  - Determine the cause of death and to
  - Better understand any impact facility services may have had on the death and when indicated, to improve policy and procedures.
- At the point of death, all decisions regarding the decedent devolve to the decedent's next of kin. All court-appointed guardianships end at the point of death.
- All state and federal laws pertaining to death shall be complied with.

Near Death

Resource center written policies and procedures shall assure that when an individual is near death, the facility shall:

- Continue care and treatment using all resources as appropriate.
- Give relief from any pain as indicated.
- Respect the wishes of the individual as expressed in any advance directive.
- Inform the individual's family contact, guardian, or other legal representative of the situation and assist in any appropriate planning.

Hospice Care

For individuals with terminal illnesses with a life expectancy of six months or less, resource center policy and procedures shall assure that:

- The individual and the individual's family contact, guardian, or other legal representative is made aware of the availability of hospice services.
- At the request of and with the written consent of the individual or the individual's family, guardian, or other legal representative, assistance shall be given in making a referral to a licensed hospice agency.
- When the hospice referral is for placement with another agency:
  - Appropriate referral information is provided,
  - It is understood that the individual will be discharged upon placement, and
  - A community physician is identified who can assume the responsibility for continuing medical services.
- When the hospice referral is for services to be provided within the facility:
  - Appropriate referral information is provided;
  - There is a written agreement as to which services will be provided by employees of the hospice agency and which will be provided by employees of the resource center;
  - The written agreement assures that the resource center's physician shall continue as the primary physician with the final authority on all medical decisions; and
  - The hospice services shall be provided on a unit that can provide the medical services specified in the plan to meet the medical needs of the individual.

Deaths Covered

Resource center written policies and procedures shall assure that the following deaths are covered under this policy:

- All deaths of individuals that occur on the campus of the resource center.
- All deaths of individuals who are off campus but who are:
  - On home visit from the resource center,
  - Placed on leave from the resource center,
  - Under the care or supervision of a facility employee, including waiver homes,
  - On temporary placement or transfer for medical treatment, or
  - Discharged from one of the statuses listed above within five days before the date of death.

Confidentiality

Resource center written policies and procedures shall assure that confidentiality concerning the individual is maintained after an individual's death. Information concerning the individual shall be released only to:

- The next of kin.
- An individual, agency, law enforcement, or licensing or accrediting body that:
  - Is governed by the same confidentiality requirements as the Department, and
  - Is legally required to be notified as defined in this policy.

Internal Reporting Procedures

Resource center written policies and procedures shall assure that:

- Procedures for providing timely notice of all reported deaths to all the employees responsible for implementation of this policy, including but not limited to the medical director, director of nursing, directors of treatment programs, and social work services shall be developed and implemented.
- The responsibilities of each employee shall be clearly specified, including duties or responsibilities and expected time frames.

Physician Responsibilities

Resource center written policies and procedures, when a death occurs, shall assure that:

- For all deaths occurring in the resource center, a physician shall:
  - Pronounce death.
  - Provide immediate notice to the superintendent or administrator or the superintendent or administrator's designee.
  - Identify the body.
  - Care for the body and secure the death scene including any possible evidence related to the death pending instructions from the medical examiner.
  - Assure that the details and circumstances surrounding the death and the actions employees took in response to the death are documented, including but not limited to the facts used to establish death, the time of death, and apparent cause of death (in the physician's best professional judgment).
  - Certify cause of death and complete the death certificate as required in Iowa Code section 144.28 within 72 hours of receipt of the death certificate from the undertaker or other person responsible for filing the death certificate.
- For all deaths occurring outside the resource center, a physician shall contact the hospital where the death occurred or the physician attending the decedent at the time of death to:
  - Confirm date, time, and place of death,
  - Determine the apparent cause and circumstances of the death,
  - Determine if the death meets any of the reporting requirements in this policy,
  - Determine if the county medical examiner was notified of the death, and
  - Document the findings in the individual's facility record.

Nursing Responsibilities

Resource center written policies and procedures shall assure that:

- The director of nursing is immediately notified.
- The nurse present at or called to the death scene shall:
  - Assist the physician in documenting the facts surrounding the death and securing the death scene or,
  - In the absence of a physician, document the facts surrounding the death and secure the death scene pending further instructions from the medical examiner.

Reporting Deaths

Resource center written policies and procedures shall assure that all deaths are reported to the individual's next of kin, the division, and otherwise as required by accreditation standards, policy, or by law. The superintendent or administrator or the superintendent's or administrator's designee, as specified in the facility's policy, shall be responsible for making the following reports:

County Medical Examiner

Resource center written policies and procedures shall assure that:

- The report shall be made immediately upon knowledge of the death to the medical examiner of the county in which the death occurred. The employee may call the county medical examiner directly or may call the local sheriff and have the dispatcher page the responding medical examiner.
- For a death occurring outside the facility, the facility shall report the death to the medical examiner even if there is information that someone else has reported the death to ensure independent compliance with the law.

  Covered deaths occurring outside the state shall be reported to the medical examiner for the county in which the resource center is located to assure compliance with the law. The notice shall be documented and include the name of the employee who gave the notice and date and time notice was given.

- For a death occurring in the facility, the body, clothing, and any articles upon or near the body shall not be disturbed or removed from the position in which they are found. Physical or biological evidence shall not be obtained or collected from the body without authorization of the county or state medical examiner. Exceptions may be made:
  - For the purpose of preserving the body from loss or destruction, or
  - To permit the passage of traffic on a highway, railroad, or airport, or
  - If failure to immediately remove the body might endanger life, safety, or health.

Medical Examiner Preliminary Investigation

Resource center policies and procedures shall assure that:

- The information requested by the medical examiner is provided promptly,
- All employees work cooperatively with the medical examiner,
- The information provided the medical examiner is documented, and
- Payment shall be promptly made to the medical examiner upon receipt of a signed itemized bill.

Individual's Next of Kin

Resource center written policies and procedures shall specify which employees are responsible to assure that the individual's next of kin shall be notified of a death as follows:

- By telephone within one hour of knowledge of the death, to:
  - Ask which funeral home is to be used,
  - Respond to questions,
  - Determine the next of kin's wishes as to any property the resource center has that belonged to the deceased,
  - Notify the next of kin of the right to request an autopsy, at the next of kin's expense, if the medical examiner does not order an autopsy, and
  - Determine whether further follow-up with next of kin will be needed.
- By written notice sent by mail to the decedent's next of kin within three days of the date of death.

Department of Inspection and Appeals

Resource center written policies and procedures shall assure that notice of any death is provided to the Department of Inspection and Appeals:

- By phone within 24 hours of the death, and
- In writing within 48 hours of the death.

Deputy Director

Resource center written policies and procedures shall assure that reports of all deaths are made to the deputy director or the deputy director's designee as follows:

- All deaths caused by abuse or which are suspicious or unexplained shall be reported within two hours of receipt of notice of the death during the workweek, evenings, holidays, or weekend.
  - During regular business day hours, these reports shall be made by phone or E-mail.
  - At all other times, the report shall be made by phone.
- All other deaths shall be reported as follows:
  - All deaths occurring between 8 a.m. and 4 p.m. on a business day shall be reported by 4:30 p.m. on the date of the death.
  - All deaths occurring after 4 p.m. and before 8 a.m. on a business day, as well as any death occurring on a holiday or weekend day shall be reported by 10 a.m. the next business day.

Involuntary Commitments

Resource center written policies and procedures shall assure that notice of the death, including time, place, and alleged cause, is sent within three days of the death to:

- The county board of supervisors of the county of commitment,
- The judge of the court that had jurisdiction over the commitment, and
- The central point of coordination of the county from which the individual was admitted, using the DHS Institutional Core Data Form 470-4161.

Voluntary Admissions

Resource center written policies and procedures shall assure that for a death of an adult individual voluntarily admitted, notice shall be sent within three working days to:

- The central point of coordination of the county from which the individual was admitted, and
- The central point of coordination of the county of legal settlement, if different, using the DHS Institutional Core Data Form 470-4161.

Protection and Advocacy Services

Resource center written policies and procedures shall assure that:

- Written notification shall be provided to the Protection and Advocacy Services for all Conner class members within five working days of the death. The notice shall include the treatment team's summary of the death.
- A copy of the notice to the Protection and Advocacy Services shall be provided to the Division's compliance officer.
- Documentation of the notice shall be placed in the individual's facility record and shall include at a minimum the date and time the death was reported to the Protection and Advocacy Services.

Iowa Foundation for Medical Care

Resource center written policies and procedures shall assure that a request for a death review is submitted to the Iowa Foundation for Medical Care as soon as the individual's file contains the information needed for the review.

Autopsy

Resource center policies and procedures shall assure that when the next of kin requests an autopsy, the next of kin is:

- Provided information as to how to request an autopsy,
- Provided with needed support in the process, and
- Informed that the autopsy will be at the next of kin's expense.

Request by Resource Center

When an autopsy is not ordered by the medical examiner and the next of kin has not obtained an autopsy, resource center policies and procedures shall:

- Provide for seeking an autopsy when:
  - There is no clear cause of death,
  - The circumstances of the death suggest that the findings of an autopsy might be useful, or
  - It is believed that the information can be used in the facility's performance improvement activities.
- Provide that if the resource center wants to request an autopsy, the superintendent shall take the following steps:
  - Request that the medical examiner order an autopsy.
  - If the medical examiner does not order the autopsy, request that the next of kin authorize an autopsy.
  - If both refuse to authorize an autopsy, consult with the deputy director or the deputy director's designee as to whether additional steps shall be taken to seek an autopsy.

  Note: If the individual's body has been donated to medical school by will or at the direction of the spouse, parents, or adult children in accordance with Iowa Code section 331.802(8) and this is known to the facility, the facility shall not seek an autopsy.
- Include the procedure for arranging for autopsy to be performed when authorized by the next of kin that includes at a minimum:
  - Identifying the pathologist to be used,
  - Making arrangements for the pathologist to examine the body, and
  - Getting the consent for the autopsy to the pathologist.

Seeking Next-of-Kin Authorization

Resource center written policies and procedures shall assure that in seeking next-of-kin authorization for an autopsy:

- When the death is expected, the process shall start before the death and shall be done in person with the next of kin. The process shall include:
  - Providing the facility's rationale as to why an autopsy is requested.
  - Exploring the next of kin's feeling about an autopsy.
  - Informing the next of kin that the autopsy will be at no cost to the next of kin, and the next of kin will be provided with a copy of the autopsy.
  - Ensuring that the next of kin clearly understands this is the decision about the autopsy is up to the next of kin.
- The facility shall document the consent, including clear identification of:
  - The relationship of the next of kin member giving the authorization.
  - The next of kin's order in the list of persons authorized to give consent.
- When the next of kin is not available to meet in person, the request shall be done by phone, covering the same information, and the facility shall:
  - Have at least two employees witness the phone call.
  - Have all employees who witness the call sign the documentation.
    - For documentation made by voice recording, signature shall be made by each witness stating name, job title, date, and time.
    - For documentation made using an electronic medical records system, signature shall be made by the witness entering /S/ followed by typed name, job title, date and time.
  - Follow up the phone consent by sending a written consent for the next of kin to sign and return.

Autopsy Reports

Resource center written policies and procedures shall assure that when an autopsy report is received:

- A copy of the report is made available to the next of kin,
- A copy of the report is provided to the deputy director, and
- A copy is placed in the deceased individual's facility record.

Property of Deceased Individual

Resource center written policies and procedures shall assure that at the time of death of an individual:

- The superintendent or the superintendent's designee shall immediately take possession of all property of the deceased individual left at the resource center.
- When there is a duly appointed and qualified representative for the deceased individual, property in the possession of the resource center shall be delivered to the representative.

Property of Small Value

Resource center written policies and procedures shall assure that the property left by the decedent shall be delivered to a surviving spouse or heirs of the decedent if:

- If within one year of the death of the decedent administration of the estate has not been granted,
- The estate of the deceased is so small to make the granting of administration inadvisable, and
- There is no claim for Medicaid estate recovery,

No Administrator or Heirs

Resource center written policies and procedures shall assure that, if an estate administrator is not appointed, a surviving spouse or heir is unknown, and there is no claim for Medicaid estate recovery:

- The superintendent shall convert the decedent's property to cash. I 0n doing so, the superintendent has the powers possessed by a general administrator of an estate.

- As soon as practicable after one year, the funds shall be transmitted to the treasurer of the state.
- The superintendent shall keep a permanent record of all funds transmitted to the treasurer that includes:
  - By whom and with whom the funds were left,
  - The amount of the funds,
  - The date of death of the owner,
  - The owner's reputed place of residence before coming to the resource center,
  - The date the funds were transmitted to the state treasurer, and
  - Any other facts that would identify the intestate and explain the case.
- A copy of the record shall be transmitted to the state treasurer.

Mortality Administrative Reviews

Resource center written policies and procedures, as part of the facility's performance improvement actions, shall assure that, at a minimum, each death receives the following reviews:

Type 1 Incident Investigation

Resource center written policies and procedures shall assure that:

- A Type 1 investigation shall be conducted of each death.
- The investigation shall review the events leading up to and surrounding the death.
- A report of the investigation shall be made using form 470-4366, *Type 1 Incident Investigation Report*. (See 3-B-Appendix for a sample and instructions.)
- A preliminary investigation and report shall be completed within 5 working days after the death and submitted to the superintendent and quality management director.
- A full investigation shall be completed within 15 working days after death incorporating the physician mortality review and the nursing peer review information, which are due within 10 working days after the death. The full report shall be submitted to the superintendent and quality management director.
- If the investigation determines that abuse or neglect may have been involved, the policies and procedures for investigating and reporting abuse and neglect shall be followed.

Physician's Death Review

Resource center written policies and procedures shall assure that a physician's death review is conducted on each death. The review shall:

- Be conducted by the physician responsible for the medical treatment of the individual and shall include:
  - A review of the background information on the individual,
  - A review of the circumstances surrounding the individual's death including but not limited to:
    - Where the death occurred,
    - Who determined death had occurred,
    - Time of death,
    - Factors used to make the determination,
    - Notifications made by the attending physician, and
    - The attending physician's opinion as to probable cause of death.
  - A review of the individual's medical record for the past 12 months covering changes in the individual's physical status and services received or omitted, including but not limited to:
    - Current diagnosis and diagnosis history,
    - Current medication and medication history,
    - The individual's health history including identified risk factors,
    - Treatment history,
    - Significant treatment medical events including outside consultations, and
    - Whether or not the individual was in restraint or seclusion within the last 24 hours before death.
  - A review of the autopsy findings (if done and available), and
  - Other documented information appropriate to the review.

- A report shall be prepared and submitted to the superintendent and quality management director within 10 working days of the death. A copy of the report shall be provided to the investigator conducting the Type 1 investigation to identify any inconsistencies between the two reports as to the facts of the case. The report shall include:
  - A summary of the information reviewed,
  - A summary of the medical care provided in the 12 months prior to the death,
  - An assessment of the medical care provided and identification of any concerns related to the care provided,
  - An assessment of compliance with physician policy and procedures, and
  - Recommendations for opportunities for improvement of policy or procedures for medical services.

Nursing Peer Death Review

Resource center written policy and procedures shall assure that the director of nursing services for the resource center shall complete a nursing peer death review.

- The review shall include:
  - A review of the background information on the individual,
  - A review of the individual's health history and nursing interventions over the past 12 months.
  - A review of the circumstances surrounding the individual's death, including but not limited to:
    - Direct care employees' observations of any changes in the individual's health or behavior status,
    - History of direct care employees reporting health or behavior changes to nursing employees,
    - History of nursing employees' response to reported changes,
    - Nursing assessments of the individual,
    - Timeliness of nursing employees in reporting medical issues to medical staff,
    - Timeliness and appropriateness of medical staff responding to reported issues.

- A report of the review shall be completed within 10 working days of the death and shall be submitted to the superintendent and director of quality management. A copy of the report shall be provided to the investigator conducting the Type 1 investigation to identify any inconsistencies between the two reports as to the facts of the case. The report shall include:
  - A summary of the information reviewed,
  - An summary of the nursing services provided in the 12 months before death,
  - An assessment of the nursing services provided and identification of any concerns related to the services provided,
  - An assessment of compliance with nursing policies and procedures, and
  - Recommendations for opportunities for improvement of policy or procedures for nursing services.

Mortality Review Committee

Resource center written policies and procedures shall assure that for every death:

- The superintendent shall appoint, within five working days of the death, a morality review committee. The purpose of the committee shall be, as part of the resource centers quality improvement process:
  - To conduct a thorough review all documentation, circumstances of the death,
  - To assess the quality and appropriateness of the services provided to the individual,
  - To identify any concerns about the quality of services provided, and
  - To recommend opportunities for improvement of the policies, procedures, or service delivery system of the resource center with the goal of improved service delivery.
- The membership of the committee shall be composed of:
  - The superintendent,
  - The physician who completed the physician's mortality review,
  - The director of nursing,
  - The medical director,

- Program treatment and nursing staff responsible for directing the individual's treatment services,
- A direct care employee who was involved in providing services to the individual,
- A social service employee providing services to the individual,
- A professional support services (OT, PT, dietary) representative responsible for providing services to the individual as part of a treatment plan,
- The investigator completing the Type 1 investigation,
- The quality management director, and
- Any other employee determined by the superintendent as appropriate to the review.

♦ The quality management director shall be the chair of the committee.

♦ The superintendent, the chair of the committee, and the medical director shall be responsible for the determination as to whether the death is expected or unexpected. The decision shall be made the same day the committee is appointed and the basis for the decision shall be documented.

♦ When the death is unexpected, the chair of the committee shall immediately initiate additional reviews of the death through an internal peer review process and an external independent physician review process.

♦ The committee shall have available all documentation relating to the death include but not limited to:

- The complete resource center record of the individual,
- All physician and nursing reports,
- Incident and other staff documentation reports related to the death,
- The autopsy report (if done and available),
- Medical reports from other facilities if the death occurred there,
- The Type 1 investigation report,
- The physician's death review,
- The nursing peer death review, and
- Any other information deemed necessary by the committee.

- The committee shall meet within seven working days of the receipt of the full Type 1 investigation report, the physician's death review report, and the nursing peer death review report.
- When the reports of the profession peer review or the independent physician peer review are not available at the time of the committee's meeting, the chair shall prepare a preliminary report to the superintendent.
  - Within two working days of receipt of the reports, the superintendent, committee chair, and the quality management director shall meet and determine whether the information is sufficient to call another meeting of the mortality review committee.
  - If the decision is that another meeting is not required, the rational for that decision shall be documented and filed with the report of the committee along with the peer review report and the independent physician report.
  - If another meeting of the committee is held, the chair shall prepare a final report that shall be filled with five working days of the meeting.
- If the autopsy report is not available at the time of the mortality review committee's meeting, this shall not delay the committee's meeting, review, and report. When the autopsy report is received, the superintendent shall review the autopsy with the resource center's medical director and the independent peer review physician, when such is required, to determine whether the findings require another meeting of the full committee.
- All information reviewed and discussed by the committee is confidential and shall not to be disclosed without the authorization of the deputy director.
- All copies information and reports used by the committee during the review are not for distribution and shall be returned to the chair of the committee upon completion of the review. One copy of all the information and reports used shall be maintained as part of the record. Duplicates shall be destroyed.
- The information provided to the committee and the proceedings of the committee shall be confidential. Members of the committee shall not disclose any written or verbal information from the meeting to another party without authorization from the superintendent.

- The chair of the committee shall prepare a confidential written report of the meeting within 15 working days of the committee's meeting. The content of the report shall be limited to the following:
  - The names of members of the review committee,
  - A statement of documents reviewed,
  - The opportunities for improvement identified by the committee, and
  - Any recommended plans for corrective action.
- The written report shall be drafted by the chair and circulated to the other members of the committee for review and comment.
- The information received by the committee and the written report of the committee shall be considered an administrative record and be maintained in a secure file separate from the individual's record. The report may be released to another resource center employee for administrative purposes with consent of the superintendent. Any other release shall require the approval of the deputy director.
- A copy of the report shall be provided to:
  - The resource center's quality performance improvement system,
  - The deputy director, and
  - The department's attorney general representative.
- The report shall not be used for any personnel actions.
- The quality management director shall be responsible for implementing and tracking implementation of all the recommendations made by the committee.

Professional Peer Review of Unexpected Death

Resource center written policies and procedures shall assure that for all unexpected deaths:

- A professional peer review shall be conducted by a professional selected by the committee who:
  - Is licensed in the profession whose area of professional expertise is most closely related to the primary cause of the individual's death, and
  - Has not been involved in the provision of services to the individual.
- When an appropriate peer is not employed by the resource center, a peer from another Department facility shall be used to conduct the peer review.

- The reviewer shall have available the complete facility record of the individual, the report of the investigator, the physician's review, the nursing peer review, and any report of the mortality review committee.
- The professional peer review report shall include:
  - Background information on the individual,
  - A review of the care provided by the reviewer's area of professional expertise,
  - A review of the events leading up to the death,
  - Any concerns, questions, inconsistencies found by the reviewer between the information in previous reports and the findings of the peer reviewer,
  - A summary of any discussions with staff to clarify any inconsistencies, and
  - The opportunities for improvement identified in services provided.
- The professional peer review report shall be submitted to the superintendent and the chair of the mortality review committee within seven working days of the mortality review committee's assignment.
- The superintendent shall be responsible for presenting the report to the mortality review committee for their review and consideration.
- This report shall not be used for any personnel actions.

Independent Physician Peer Review

Resource center written policies and procedures shall assure that for all unexpected deaths:

- A licensed physician who is not employed by the resource center shall conduct an independent physician peer review.
- The reviewer shall have available
  - The complete institutional record of the individual,
  - The report of the investigator,
  - The physician's review,
  - The nursing review,
  - Any report of the mortality review committee, and
  - Any other documents or information the reviewer believes is relevant.

- The purpose of the review shall be to:
  - Evaluate the medical care provided to the individual by the resource center's physicians and other appropriate clinical disciplines based on current standards of care for the profession being reviewed.
  - Provide recommendations to the resource center for opportunities for improvement of the clinical services provided to individuals.
- The reviewer shall prepare a report based on the evaluation and identify any recommendations for opportunities for improvement in the quality of care being provided.
- The report shall be submitted to the superintendent and the chair of the mortality review committee within 25 working days of the determination that the death was unexpected. If all external information is not available (i.e. the autopsy report), the report shall be submitted on a preliminary basis and the report finalized with five working days of the reviewers receipt of the missing information.
- The superintendent shall be responsible for presenting the report to the mortality review committee for their review and consideration.

POLICY ON PEER REVIEW

Each resource center shall continuously seek to improve the quality of services to the individual's served. The quality management principles listed below using current standards of practice in the healthcare community shall be used to implement peer reviews and integrated care reviews with the goal of improving the quality of care given at the resource center.

To ensure quality care is maintained and continuously improved, professional accountability and clinical judgment shall be evaluated against practice standards established by each professional specialty.

Peer Review Principles

Resource center written policies and procedures shall assure that peer review processes shall be guided by the following principles:

- Responsible healthcare requires an integrated approach to quality, which is transparently measured against currently accepted standards of practices.
- Peer review is a quality improvement initiative driven by the desire to improve services and outcomes for individuals who live at the resource centers.

- Peer review is most successful when implemented in a culture of learning, free from blame.
- Professional development occurs most readily in a strength-based environment that:
  - Is driven by recognized strengths and abilities of the individuals served as opposed to recognized deficits,
  - Fully utilizes and builds upon those strengths and abilities to meet personal and organizational goals, and
  - Emphasizes and encourages learning and responsibility.
- Properly implemented, peer review processes will result in integration and multidisciplinary learning through team building.

Peer Review Required

Resource center written policies and procedures shall assure that

- The following professional specialties shall conduct specialty peer reviews:
  - Dentistry
  - Dietary
  - Medicine
  - Neurology
  - Neuropsychiatry
  - Nursing
  - Occupational therapy
  - Physical therapy
  - Psychiatry
  - Psychology
  - Speech and language pathology
- The deputy director shall approve all peer review schedules.

Peer Review Performance Improvement

Resource center written policies and procedures shall assure that quality management practices are in place to:

- Monitor the implementation of peer review;
- Identify systemic issues, actual or potential, needed corrective action; and
- Monitor the completion and implementation of corrective action plans.

Data Collection and Review

Resource center written policies and procedures shall assure that:

- Reviews shall be documented in a standardized format.
- Review data shall be tracked and reviewed by the quality council.
- Review data shall be electronically maintained by:
  - Specialty area
  - Date and type of review (internal or external)
  - Participants' names and titles
  - Review content, including:
    - Focus of meeting, e.g., individual cases, system, process, etc.
    - Standards of practice applied
    - Findings and outcomes
    - Issues identified
    - Type of issue identified (individual, systemic, procedural, etc.)
    - Corrective action plans developed when indicated, including responsible persons and the date by which such actions shall be completed
- Each specialty required to do peer review shall provide a brief presentation to the quality council at least annually, describing:
  - What changes have occurred in assessment and treatment;
  - Quality or performance improvement initiatives implemented;
  - Changes in outcome and performance measure data;
  - Lessons learned; and
  - Actions planned (including corrective actions and improvement plans).

Staff Training and Education on Peer Review

Each resource center shall create and maintain a learning environment that supports on-going education initiatives. Specifically, resource center policies and procedures shall be written and implemented to assure that:

- All newly hired employees who will be providing direct services or supports to individuals shall receive basic training on the purposes of peer review and the benefit of this practice to the individuals residing at a resource center.

- All professional employees involved in peer review processes and their supervisors shall receive initial and annual competency-based training on:
  - The principles and benefits of peer review,
  - Procedural guidelines in conducting internal and external peer reviews, and
  - Current approaches and advancements in healthcare peer review practices.
- All employees who provide clinical services in the listed specialties shall receive annual competency-based refresher training on peer review practices.
- Training and education shall be documented in each employee's training record.
- Employee training shall be implemented in a timely manner.
- Clinical employees shall have opportunities, resources, and time allotted for professional development and education that is required to perform their duties.
- Peer review competency-based training curriculum shall be updated to reflect current professional standards for peer review.

POLICY ON QUALITY MANAGEMENT

Each resource center shall continuously improve the quality of services it provides. Continuous improvement is best achieved when leadership is committed to excellence, there are established performance expectations, and there is a formal quality management system.

"Quality management" is a planned, systematic, organization-wide approach to the monitoring, analysis, and improvement of organization performance, thereby continuously improving the quality of patient care and services provided and the likelihood of desired patient outcomes. (Source: JB Quality Solutions, Inc., The Healthcare Quality Handbook 2005)

A quality management system is focused on improving all services, systems, and processes within an organization. This approach to health care involves each person in the organization, recognizing that the "whole" is dependent upon its "parts." Quality management is based upon the question of "How can we do better?" (not "What did we do wrong?"). Quality assurance is not to be used in a punitive manner.

In its simplest form, quality management is the pervasive and continual pursuit of excellence. An effective quality management system requires that there be strong, proactive leadership, sound structures and processes, and an environment conducive to continuous quality improvement.

Quality Management Principles

Resource center written policies and procedures shall assure that:

- A culture of quality management philosophy shall be created and integrated into the general operations of the facility and shall reflect the following principles of quality:
  - An individual's well-being is a bio-psycho-social condition and cannot be conclusively measured compartmentally.
  - Effective decision-making involves those managing services, those providing services and, most importantly, those receiving services.
  - Effective results for an individual are achieved by integrated service delivery that is based upon currently accepted standards of practices.
  - The pursuit of "quality" has no final destination as it is fluid, changing with an ever-growing knowledge base.
  - Employees operate through processes developed within a system. Therefore, to ensure positive change, systems and their processes must be thoroughly assessed and taken into account before employee performance is evaluated.
- All employees shall be committed to continuous improvement of care for each individual and are directly responsible for the quality of services provided to individuals served by the resource center.
- Leadership shall be committed to and foster multi-disciplinary teamwork including all employees working with individuals.
- Leadership shall understand and recognize the interdependence of allied health services and the skill base each brings to quality health care.
- Leadership shall utilize and build upon the strengths and abilities of each employee to meet personal and organizational goals.
- Leadership shall create a culture of continuous improvement and shall emphasize an encourage learning and responsibility.

Facility Leadership Responsibilities

Resource center written policies and procedures shall assure that:

- Facility leadership is knowledgeable of current best practice standards.
- Facility leadership is responsible for ensuring that facility practices are consistent with current standards of care for individuals with developmental disabilities.
- Facility leadership is committed to the institution of quality and shall foster this throughout the organization with all employees.

Structures and Process

Resource center written policies and procedures shall assure that:

- Structures and processes shall be established to implement quality improvement initiatives effectively.
- A quality council shall be established to oversee the quality assurance and performance improvement practices facility wide. The council shall meet no less than monthly.
- The council shall be composed of leaders in the areas of administration, clinical review and direct service management including but not limited to:
  - The superintendent, who shall chair the council;
  - The director of quality management;
  - Assistant superintendents;
  - The medical director;
  - The directors of psychology, nursing, and habilitation;
  - Directors or lead persons in dietary, occupational therapy, physical therapy, speech/language therapy, and psychiatry;
  - A qualified mental retardation professional;
  - Treatment program administrators; and
  - Other key persons.

- The quality council shall:
  - Review clinical and performance outcome reports that focus on individual safety and wellness, client growth, and independence and facility practices. The reports shall include quality indicators as determined by the deputy director.
  - Review and refine systems and processes to better integrate and streamline services.
  - Assist interdisciplinary teams as appropriate.
- The quality council shall keep minutes of its actions in the format specified by the deputy director. At a minimum, the minutes shall, include the following information:
  - The meeting date, chairperson, members present, members absent, and the recorder.
  - The topics discussed at the meeting, a list of the handouts used, and a summary of the discussion.
  - The corrective actions identified, the person responsible for implementation, and the due date.
- Each specialty area, or discipline, resource center department director or responsible supervisor, shall assure that:
  - Employees shall be knowledgeable about and apply current professional knowledge in the field;
  - Current professional standards of practice and measurable outcomes shall be identified and monitored;
  - Professional practice is evidence-based, whenever possible, and minimum standards of quality care shall be identified and monitored; and
  - Employees closest to the individual and responsible for implementing programs shall be actively recruited for their assistance in identifying opportunities for integration of programming.

- Supervisors and managers shall maintain close contact with their employees to foster the pursuit of quality and assess its progress. Meetings shall occur regularly with all employees to assure their understanding and involvement in quality improvement processes, which shall include:
  - Defining, measuring and improving quality,
  - Implementing quality initiatives in their respective area.
- Supervisors and managers shall maintain effective communication processes to ensure employees remain involved and knowledgeable of quality issues, including individual and facility outcomes, and improvement initiatives.
- Supervisors and managers shall assure the integration of the concept and expectation of quality care into position descriptions and performance evaluations.

Environment

Resource center written policies and procedures shall assure that:

- There shall be a continuous assessment of the culture of the facility, with specific focus on any attitudinal barriers affecting the implementation of self-determination and person-centeredness. Identified issues shall be addressed.
- There shall be ongoing processes to assure that employees are up to date regarding current disability-rights issues and to ensure that the facility's practices are congruent with contemporary thought and practices in the community. Identified issues shall be addressed.

Quality Performance Improvement

Resource center written policies and procedures shall address quality assurance and quality improvement efforts directed towards improvement of services and shall assure that:

- Key performance data shall be routinely collected and analyzed.
- Quality performance indicators and reporting formats shall be identified by July 1 of each year.
- Corrective or improvement activities shall be based upon relevant data.
- Data collection activities shall assure data integrity and reliability.

Quality Reporting Requirements

Resource center written policies and procedures shall assure that:

- Systems and methods shall be in place to assure the collection of key performance and performance data on a monthly basis. Other data items will be collected as defined by the quality councilor the deputy director.
- At a minimum, the outcome and quality indicators shall include the data items determined by the deputy director.
- Quality council minutes shall be provided to the deputy director on a monthly basis in a format determined by the deputy director.
- Written policies and procedures shall assure that performance and quality management data is provided on a monthly basis to the quality council.
- Policies and procedures shall assure that monthly data is reported to the deputy director in the required format.

Employee Training and Education on Quality Management

Resource center policies and procedures shall be written and implemented to assure all employees receive based training on quality management principles.

Upon hire and at least annually thereafter, all employees shall receive competency-based training on quality management issues including:

- Terms and processes related to "quality."
- The principles upon which quality management philosophy is built.
- The Department and resource center commitment to quality.
- How quality is defined, measured, and reported.
- The integration of quality measures across service areas or domains.
- The purpose and importance of data collection including:
  - Documentation requirements,
  - Data authenticity and reliability, and
  - Data integrity.
- The role of internal quality management systems.
- Specific quality indicators relevant to the employee's job assignment.
- Tools, reports, and other mechanisms used by the resource center in the provision of quality healthcare.